

Clinical practice – ethical issues

Notes from Task Force work group meeting

November 19, 2008

- **Healthcare workforce – continuity, protection**

- How do you get staff to come to work? Concerns include child and family care issues, disease at home, risk of transmitting disease to family. How do we prepare staff to have “ice water in their veins” to make and live with their decisions?
- People’s commitment extends so far as their institution is prepared to protect them in the work environment. All have different family needs – each must decide how they will operate in the situation. Some will “disappear” and come back later. Can adjust burden before the event, discuss the possibilities.
- Should administrators assume percentages of absenteeism? Should have the conversations now, in preparation. What are hospital’s assumptions about staff reporting for duty? What supports for staff?
- Level and numbers of staff absenteeism are basis for administrative planning. Have staff ratios that must be maintained to provide adequate care.
- Hospital systems – may plan across system to identify one pandemic facility, and then assign staff –who goes where. A-B plan, for who does what and who goes where. Most plans don’t address the higher risk situations, just who comes in for disaster response. Biological is a different plan that most hospital emergency plans. Very different from a hurricane. Large percentage of staff at risk. Large number of contingencies that must be faced – supply chains, cascading effects, longer term scenario – weeks of response, not days. We plan, but in the event, we will do the best we can.
- Plans are now for regionalized response to hurricane. In global event self-reliance will be key, because all are dealing with the same issues, and we cannot bring in outside help.

- **Triage**

- Important to separate triage officer duties from care provision. Important to separate this for fairness and equity. Need system to reevaluate as time goes on. Are we doing the right thing?
- Is this person sick enough? Or too sick? Initial evaluation is key. Triage as 24 hour assessment. May need to reevaluate at 48 hrs, other time points.
- Triage in community, not in hospital, must be addressed.
- Reassessment of ICU pts is a seismic shift – we don’t do this now. So, how do you bring triage into care giving part?

- How can I care for patient, then ship them off to the morgue for a patient with better chance of survival? We don't triage people out of care now – this is a major shift. There won't be the luxury of separating triage completely from care giving. It would be hard to maintain objectivity, and have good criteria for review.
 - Based on patient condition (deterioration) to stop active treatment and shift to palliative.
 - Designated facilities for treating critical care patients may be good approach. County referral center, set up with rules and team. Flow of patients will push decision making.
 - Where do you put family in decision tree – now? In pandemic? This is an alternate care standard. Public needs to know that the standards have changed, and that all are treated "fairly." Need family counseling and description of the decision making process that the hospital will use.
- **Alternate standards**
- Plans address initial care team (after triage) who you need and number of staff needed. This gives an idea of the pool of caregivers needed. Who triggers the alteration of standards of care? When? Who is going to tell the hospital administrators?
- Allocation of scarce resources – ICU, ventilation
- Reallocation of medical providers
- Alternate care sites
- Roles & responsibilities of house staff
 - "Presenteeism" – do I come into work when mildly ill? Duty to stay home, or come in to provide care? Do I work when exposed? Duty to self, patient, or community? May need to set thresholds – fever, other criteria. Ethic to not spread germs. This raises the issue of lack of staff to a higher problem.
- Palliative care
 - Care for people triaged out
 - Home care
 - How do staff provide lower levels of care, make recommendations to families – do we triage cases over the phone? Do hospitals refuse to see patients? What should be done regarding outpatient triage? Recommendations for care? Getting medicine to the sick people in the community?
 - Set up for palliative care in alternate care sites
 - Code of ethics – nursing - duty to patients comes first

- In essence, shift in focus to treatment of the community
- Care for patients who do not have influenza: heart disease, appendicitis – do you turn them away? Give preference? Direct patients to one particular hospital (away from influenza cases). Would need to plan for this in advance, for system to direct patients.
- Military triage – who can be saved, “expectant” patients expected to die. In the middle of a war, this is done, not otherwise.
- US – ample health care resources for extensive care for patients. Not so in a pandemic. What is the trigger to go to a different level of care in a pandemic? Who decides? Emergency Health Powers activation – is that the trigger?
 - May set trigger point early in pandemic – now's the time – before epidemic is full blown
- Harder to decide to take people off ventilators that to decide not to put them on the vents in the first place
- What practitioners are allowed to make decisions – PAs, nurses – do they make choices formerly made only by physicians?
- Implementation of public health measures by the health care providers. Clinical implementation – what is impact? When do you cancel all elective procedures? Need guidance. Don't assume people will stop wanting elective procedures during a pandemic.
- What form should alternate standards of care take? What is relation to law? Where do clinical practice guidelines fit into the legal aspects? How do we state them?
- Could take many forms. If situation is medical malpractice lawsuit. Be non-negligent = a standard of care. What a reasonable practitioner would have done – reasonable person standard. High level standards. Cases funnel down to specifics: non-negligent to reasonable care – to doing all possible to save the patient to specific detailed clinical practice guidelines: if xyz, then this is the protocol, step by step. Either you get consensus among parties that there is a single set of applicable guidelines. Alternative, competing guidelines and the practitioner chooses. Plaintiff's expert may say guideline B was the right one. Ultimately, practice guidelines fit into this context. So, state guidelines will be what practitioners are judged by. How can we remove the “alternative guideline” argument from litigation in the aftermath. Triggers: creation, promulgation, and consensus on guidelines represents new practice standards for the particular pandemic situation. Defense against med malpractice is based on non-negligence, reasonable care, and following appropriate practice guideline. Range of standing orders, provided this is implemented in a state of emergency, must meet federal CMA standards/guidelines to fund treatment. Reimbursement is an entity concern, CMA however, regulates patient care too.

- Look at examples from other states on liability immunity (a completely separate legal issue).
- What is the impact of clinical practice guidelines issues by state? No legally binding effect. For any particular situation, there can be competing guidelines. Up to the professions, with a variety of bases including empirical evidence. Voluntary to mandatory continuum for applying guidelines.
- **Mental health issues**
 - What are obligations of psychiatrists – do they give primary care too?
 - People will be traumatized, including practitioners. High level of trauma for health care workers
 - Altered standards for mental health patients – can't hold them for evaluation as usual. Requires changes in practice.
 - Designation of facilities – some must be designated for influenza, some for other types of care. If you have this condition – go here for evaluation and care. Limit services offered by particular facilities to limit exposure – alternate care sites – ambulatory care centers for example.
 - What if – designated flu hospital? Is it the plague hospital now? Will hospital go out of business?
 - Will patients obey the designation? No. not feasible. How to enforce?
 - Obligation of professionals to care? Licensure and regulation if professionals refuse to work.
 - EHPA can mandate professionals to work. [If so, so what? Extremely problematic to implement.] EHPA can make hospitals serve people.
 - Nowhere has this situation been faced in reality.
- **Antiviral allocation**
 - Antiviral allocation to hospitals. What do we need to address at this level of detail? No antiviral police to enforce the agreements? Same for vaccine. Limited amounts available.
 - To prophylax or not to prophylax, that is the question? Viral adapts quickly, so antiviral should only be used for treatment, not prophylaxis. Can search the literature as a way to guide decision. Will still need to write the rule. Evidence based guidelines to apply in hospital setting. Transparency, based on scientific evidence.
 - Issues for PPE and infection control. Practical issue: Supplies of PPE may be a limiting factor. Full gown, respirator only... depends on what we know about

transmission. Standards for PPE protocols would help across providers. Better to set guidance before than during the event.

Next meeting: January 21, 2009

Co-coordinators: Dr. Limehouse, Dr. Foster, Dr. Fabian

Distribution of materials by OPHP: via email

Next meeting: Full task force meeting in January 21, 2009

Clinical practice group will meet that day.

Homework:

Review bibliography – download what you need to read or request copies.

Staff needs to send to work group: bibliography.

Share resources via DHEC staff: Dr. Fabian, Max Learner.

Make list of all work group members.